DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11042 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Amendment Request Completion Instructions (HCF 11042A).

SECTION I — RECIPIENT INFORMATION

1. Today's Date	2. Previous Prior Authorization Number
3. Name — Recipient (Last, First, Middle Initial)	4. Recipient Medicaid Identification No.

SECTION II — PROVIDER INFORMATION

5. Name — Billing Provider	6. Billing Provider's Medicaid Provider No.
7. Address — Billing Provider (Street, City, State, ZIP Code)	8. Amendment Effective Dates

SECTION III — AMENDMENT INFORMATION

9. List reasons for Amendment Request

10. Indicate procedure(s) to be amended by hours per day and days per week, multiplied by the number of weeks.

Registered Nurse _____

Licensed Practical Nurse _____

Home Health Aide _____

Physical Therapist _____

Occupational Therapist _____

Speech-Language Pathologist _____

Personal Care Worker _____

Other _____

11. **SIGNATURE** — Requesting Provider	12. Date Signed

Reset Form